Sight Conservation Through Fuller Understanding of the Patient

A Symposium

Supplement

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Sight Conservation Through Fuller Understanding of the Patient*

A Symposium

Presiding: LENA R. WATERS, *Chairman*

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CHAIRMAN WATERS: The leaders of modern medicine have given much emphasis to the importance of having the patient participate fully in his own treatment. On the whole, this thinking has been applied to the adult patient. The importance of this modern approach to the child patient is stressed in the papers presented by three medical social workers. The writers of these papers are close to the problems through their daily work; thus their presentation is both vivid and authoritative.

The importance of preparing the child for the clinic experience, and of considering the child as a constantly changing organism who is approaching adult life by an orderly growth, cannot be over-emphasized. The factors which have created the attitudes of the parents and the children are many and complex. The different combinations of factors in the lives of these people necessitate individualized social study and treatment. As children grow into pre-adolescence and adolescence, their lives naturally become more complicated, and it is often essential for the medical social worker to give more intense study to this age group. The general emotional adjustment of the parents and of the child conditions his reaction to all eye disabilities; therefore, this is of primary importance in the conservation of sight.

* Presented at the Annual Conference of the National Society for the Prevention of Blindness, New York, October 27, 1939.

The Young Child with a Visual Handicap

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IN DISCUSSING the problems of the preschool child with a visual handicap, I have tried to extract those elements which are peculiar to this group. Generically speaking, problems differ with each individual regardless of age or diagnosis. In narrowing down this study to this comparatively small group, I am reminded of the old country physician who sent his son to medical school. After a few months his son wrote that the science of medicine had become so extensive that it was necessary to specialize and that he had decided to become a specialist in diseases of the foot. His father replied, "Dear Son: Which toe?"

Although the problems of this group are as varied as they are in individuals of any age, there are certain characteristics about which social workers should be concerned. In the first place, it is often difficult to detect visual handicaps in the very young child. Yet, the success of treatment for many eye conditions depends upon early diagnosis and treatment. In the second place, visual defects which handicap a child in his normal adjustments leave the most lasting traces on his personality, for, as we all know, these early years are the most formative in the development of habits and attitudes.

Eye workers know how haphazardly visual defects in the very young child are detected and how frequently they reach the eye physician only by chance. The District of Columbia Society for the Prevention of Blindness has been fully aware of this problem. Last year they sent a group of well-trained volunteers to do vision testing in the child welfare centers of Washington, D. C. These centers follow the development of well babies from infancy to school age. Of the 508 children tested, 10 per cent were found to have visual acuities of 20/40, or less, or other obvious defects, such as squints, muscular imbalances, and external diseases. They also

found they could test the vision of children from the age of three years with reasonable success. This 10 per cent indicates that visual handicaps are a very real situation among preschool children. Most of these cases would not have reached the eye physician at this time, as the parents were either not aware of visual defects or they did not feel that they were of sufficient importance to be treated while the child was so young. The latter was particularly true of squint cases. In passing, I should like to tell you the rhyme one of our doctors recites about these patients. "Treat before seven, many cures before eleven. Treat after seven, few cures under Heaven."

Before the child enters school he has not yet been confronted with close work and his lack of sight is less noticeable. Even in those cases where there are manifestations of lack of sight, parents may believe these signs to be due to other causes. The following patient illustrates this point:

> Richard, age four years, seemed to be a very retarded child. He had been a premature baby and his mother accepted the fact that he was slower in development than her other children. Richard was unusually clumsy and frequently hurt himself falling over objects. He clung to his mother constantly and depended heavily on her and the other children to help him with his dressing and feeding. He could not be encouraged to play freely with other children of his age. Examination in the clinic revealed no physical basis for his apparent retarded development. A worker in the clinic who was well trained in child care visited the home and noticed the fear he had of bumping into objects and his reluctance to move without guidance. She arranged for an eye examination. His visual acuity was determined to be too low for the child to be able to see well. He was given glasses, with dramatic success. The clinic worker explained to the mother the relationship between Richard's visual handicap and his fearfulness and need to depend on others. The mother, who was a well-balanced person, was able to see that Richard's glasses now gave him nearly normal vision and that he was able to take more responsibility for himself. She slowly encouraged him to learn how to dress and feed himself and to play with other children. Richard, once fearful and clinging, is developing into a laughing, playing child, who is now more able to cope with the various problems of growing up.

A child born with a visual defect is not able to explain that he cannot see well, for he has not experienced good vision and does not realize that his vision is poorer than others. Even if partly realized, few children of three or four are able to articulate such a difficulty. The doctors in our clinic have noticed that the small child, in particular, and even an older one, will not say he cannot see, but will respond to questions by a dull, expressionless gaze which soon wanders from the object in spite of all coaxing. When the visual handicap necessitates depending on others, the child is naturally retarded in those years when he is, or should be, most rapidly achieving independence and self-mastery as an individual. For this reason, early diagnosis and treatment are important before the dependence has become a deep-rooted habit.

Parents may lack understanding of the cause even when the defect is physically evident.

> Joan's eyes began to cross when she was three years old, becoming most noticeable when she was tired. Her mother, who was a high-strung, nervous person, thought it was merely a habit that she was developing. Whenever the squint appeared she ordered the child to hold her eyes straight and nagged her continually. Two years later, a physician suggested that she be examined in the eye clinic. The squint had now become marked. In other respects, Joan was an unusually attractive child. In the first examination, Joan became self-conscious and shy whenever any attention was drawn to her eyes and the doctor had to go slowly with her to gain any co-operation. The doctor explained to the mother that Joan could not develop the squint wilfully and should not be blamed for its occurrence. From her discussion with the doctor, the mother seemed to gain some understanding of the child's eye condition. However, other problems arose. Whenever Joan was slow in responding or had difficulty in reading the chart, her mother called sharply for her to pay more attention. The doctor told the mother that it was folly to force a child to see and that the examination must be relaxed and unhurried. Following this the mother exercised supreme self-control and remained silent during the examination. For a time the doctor prescribed glasses and a patch over the strong eye as treatment. On each clinic visit Joan begged the doctor to tell her how much longer she would have to wear the patch and how soon she might enter school. When the question came up of

sending Joan to kindergarten, the doctor suggested that the patch be left off during school hours. The mother preferred to leave the patch on if this would hasten improvement. When the doctor remonstrated with her for allowing this child to be an attention-receiving oddity before the other children, the mother decided to keep the child at home in favor of wearing the patch constantly. Joan's expectant face fell to an expression of passive defeat and she left the clinic without a word. The worker discussed the situation with the mother and found that she had little understanding of the child's point of view. Her one desire was to secure correction of the squint as soon as possible. She confessed that she was often impatient with Joan as she felt that she was old enough to realize that carrying out the doctor's orders faithfully was for her own good. The mother had also been troubled with a thyroid condition and knew that her nervousness affected her treatment of Joan. When the worker suggested that rigidly enforcing the medical treatment might only make the child hate the whole process and resist it, the mother replied that she had not been aware that Joan objected so greatly to the patching. On the surface this appeared true, for Joan was a quiet, passive child, who had apparently learned that there was little hope of resisting her mother's strong will when she had decided on a course of action. After discussing Joan's pathetic eagerness to stop wearing the patch and the way in which treatment was preventing her normal desire to go to school, we believe that this mother is gaining some insight into the negative value of forcing her to follow treatment, rather than respecting her as an individual and gaining her co-operation in a normal way. We encouraged the mother to seek medical attention in order to relieve some of her own tension.

This case illustrates the part parental ignorance and emotional attitudes can play as potential handicaps to effective treatment and further adjustments for the child in the widest sense. The alarming point in this situation was the child's passive defeatism and less evident signs of growing hatred for anything concerning her eyes or their treatment. Such a child may build up a host of negative feelings towards the treatment of her eyes so that she becomes incapable of accepting her own responsibility for their care in the future. As the child grows older and must accept more responsibility for the care of her eyes, her resistance may materially handicap further treatment.

Eye physicians have long realized the wisdom of modifying treatment for the very young child. The tendency to rebel against restriction is instinctive from birth. The month-old baby will cry and become infuriated if his arms are held forcibly to his body. The child with more experience may still meet restriction with open rebellion, or as in the case of Joan, he may become overwhelmed by the futility of resisting. Normally, he will accept the limits of the restriction without allowing it to encompass his whole being. The child is more likely to accept eye treatment if it does not unreasonably interfere with his desires and activities. He is not likely to be accepting if the restriction seems to him to be an arbitrary power his parents and the doctor wield over him for their own emotional satisfaction. Getting the child to help with treatment, even by so simple a procedure as holding his own lids down, may increase his own feeling of importance in the whole process. Eye physicians, social workers, and the parents must weigh carefully these psychological values in their relation to the medical treatment.

I should like to bring up one other point in regard to treatment, and that is the use of a positive approach. In the first place, even small children are capable of understanding the necessity for treatment if it is explained to them in their own terms, and care should be taken that they receive a logical explanation. Secondly, the constructive aspect should be emphasized. Following this line of thought, a child must wear glasses, *not* because his eyes are crossed and he has bad vision in one eye, *but* because his glasses will cure his squint and enable him to see better when he works and plays.

There is a positive side to the most negative situations. One child of five, suffering from glaucoma, had his eye removed. He had previously undergone so much surgical and medical attention that the removal itself did not present any particular problem. His father and mother thought the situation over carefully and decided to allow the child to participate as much as possible in securing a glass eye. Although the social service department helped the family buy the eye, the patient contributed ten cents which represented his life savings. His family suggested to him that few people had the distinction of wearing a glass eye and built up in him a special pride of its possession and care. Today, the patient is proud that the eye is so perfectly matched and the muscular movements so well

co-ordinated that few people realize that he has an artificial eye. He is now in school and his crowning satisfaction was the day his teacher sent home a note to his parents suggesting that he have an eye examination since he occasionally seemed to have a slight squint.

The following patient is one in whom emotional problems originated at an early age. They were neglected and finally resolved themselves into a severe pattern which materially hindered the child's recovery. The social treatment is obviously poor, but it shows the development of an emotional problem in a young child.

Mary developed inflamed eyes with corneal ulcers at the age of two. She had been treated for two years by a private physician and at the age of four came to the eye clinic. Although the symptoms resembled those of phlyctenular keratitis, at no time did the doctors feel that it was typically this diagnosis. When she was first seen in eye clinic, she was a pathetic, whining child, who held her head ducked down with her lids nearly closed to protect her eyes from the light. She clung to her mother and fretted constantly for her attention.

The parents were deeply concerned about the child and had done everything within their limited means to carry out the medical treatment. When Mary's eye condition appeared, each member of the family sacrificed to give her the food and care she needed. When Mary came to clinic, the social worker discussed with the mother the problem of Mary's irritability and her dominant position in the family. The mother was partially aware of this problem and sometimes felt the child was purposely difficult, but she was so concerned about securing the necessities for Mary that this problem fell into the background. Both the worker and the mother became absorbed in finding ways to provide for Mary properly. Treatment in the clinic was unsuccessful and the doctor sent her to a convalescent home. Within a short time Mary put on weight and the inflammation of her eyes decreased markedly. In the association with the other children she lost many of her pettish ways.

At the end of four months Mary was sent to the clinic for examination. Although alone, she sat up straight and chatted merrily with the doctor. The doctor found the eye condition quiet and said that she could be considered cured for the present. It was under very encouraging circumstances that Mary returned home. Her father was now employed and while the

income was not great, it was steadier than the family had known for years. The parents were greatly encouraged and optimistic about Mary's ability to lead the life of a normal child.

A year passed and Mary, now six years old, was brought back to clinic. She was again in poor physical condition and her eyes were slightly inflamed. Her head was held low and her eyelids nearly closed. The doctor noted that the "squinching" of her eyes and apparent irritation from the light now seemed more habit than reality. Although the value of convalescent care had proved to be only temporary, the doctor felt it was important to send the child again, in order to check further inflammation of her eyes. The mother reported that Mary had maintained her good physical condition for a while. Then the mother had become chronically ill with neuritis and there had been some financial stress in the home. The family had not given Mary the customary attention. Mary began to refuse to eat properly and had eaten candy between meals, which the parents were apparently helpless to control. The mother's dominant feeling for the child was one of pity since she had known nothing but illness from babyhood. She knew that she and the father had spoiled Mary, but they were willing to follow any course in order to secure her recovery. At this time, the mother was unable to accept the worker's suggestion that spoiling Mary had helped to develop her poor feeding habits, and that Mary, threatened by her mother's illness, was now clinging to her eye disability because of the power it gave her in the family group.

Mary's adjustment in the convalescent home was not good. She had been sent to a different one where the children were older and less controlled by supervision. She was not happy and made few friends. At the end of her allotted period there had been no great improvement either in her physical condition or her eyes. While plans were being made to bring her home, her mother again became ill and had to enter the hospital. The mother now seemed to show some traces of impatience with Mary's demands for attention at home and a growing suspicion that the price of spoiling outweighed the benefit to the child. The worker feels that it is necessary to utilize psychiatric advice to meet the complex needs of this child at present. Her problem was present early in the case, but in the pressure and dire necessity of providing her physical wants, the worker neglected the opportunity for early treatment. She was partially misled by Mary's natural irritability caused by the discomfort of her eyes and the parents' sincere desire to carry out the medical treatment.

The danger of becoming preoccupied with the diagnosis and material services may well be re-emphasized here. When a case of phlyctenular keratitis is referred to the social worker, she should guard against thinking of the case purely in terms of hygienic environment, cod liver oil, milk, orange juice, and green vegetables. These points are the mechanics of the case and not distinctive to social work. This knowledge is also the tool of the doctor and the nurse. What a social worker can contribute is the understanding of the significance of this treatment to the child as an individual in his family and social setting. She must also convey this understanding to the child, the parents, and possibly the doctor, at the same time insuring the effective carrying out of the treatment.

In conclusion, the foregoing cases were used to illustrate that the problem of visual handicap in the very young child can be as complex and severe as in individuals of any age. In my experience with eye cases, I have felt that visual handicaps, although not usually thought of as illnesses, can produce similar problems as cardiac or orthopedic disabilities. I do not wish to imply that having an eye disability at any early age necessarily means that there will be emotional problems. Many children are able to find satisfactory adjustments regardless of the severity of their eye conditions.

The distinctive factor in case work with preschool children is that their problems are incipient ones. Early correction can prevent serious difficulties later. Awareness of the possibility of difficulties in certain situations may prevent them from appearing at all. Work with the young child requires a special skill for understanding a child from his behavior and attitudes rather than from what he is able to express verbally. This skill is essential if early treatment is to be effective both physically and emotionally.

The Older Child with Eye Difficulties

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IN CONSIDERING the emotional adjustment of any child with a visual difficulty, several questions at once come to mind. What is the nature or severity of the eye disease or abnormality? What are the child's own feelings in relation to the handicap? What attitudes toward the child are seen in persons in his own immediate group? These are some of the factors we should like to explore a little in our discussion. It is true we cannot say any of these factors may exist alone, as in almost every case there appears to be an intermingling. It would seem, then, that the problem of the child with a visual handicap is much greater than the actual abnormality as seen from the medical point of view. Whether we find ourselves dealing with a withdrawn, self-pitying, dependent child or one who seems to have accepted his handicap in an easy, matter-of-fact way, it would be interesting to discover what factors have contributed to the poor or good adjustment, and most of all what rôle is indicated for the medical social worker.

Freda M.

When eight-year-old Freda M. was first seen in the Eye Clinic, a diagnosis of malignant myopia of both eyes was made, prognosis being very poor. Corrected vision was about 20/100. The parents were not unprepared for the unfavorable prognosis, since the doctor who had examined Freda in their native city in Germany the previous year had told them the child would be blind in a few years. At first they had been quite unwilling to accept the doctor's opinion. They presented a picture of a closely knit family group, the parents intelligent and resourceful, eager for advantages for their three children. These, of whom Freda was the oldest, were all bright, healthy, attractive and outgoing. After some months of close clinic follow-up, Freda was referred to a sight-saving class, making an excellent adjustment. Meanwhile, the mother rapidly learned to speak English in order that she might not handicap

the children. After the first year, it was no longer necessary for the father to take time off from his work to bring Freda to clinic, since the mother was able to discuss plans directly with the doctor and the worker. The mother readily accepted suggestions made regarding the child's care. Since Freda was a gay, independent child, definitely a leader in play activities, it required much watchful guidance on the mother's part to direct the child from too active games without developing in her a feeling of frustration.

In about two years, a detachment of the retina occurred in the right eye and six months later enucleation became necessary. Further destruction took place in the left eye, reducing the vision to 20/200. The parents, though much upset, managed to conceal their feelings from the child, who did not seem fearful.

Later, transfer to a Braille Class was arranged, Freda making the adjustment easily. Because of the long trip involved, the family moved to the east side. Then the mother became aware that Freda missed her friends in the former German neighborhood and they moved back. The mother continued accompanying Freda to school for a time, then decided it might tend to make her dependent. At first, the mother was filled with anxiety lest danger befall the child, but was able to carry it through. In this typically German home, Freda has always had her share of household tasks and activities, a definite plan on the part of the mother. We see her now, an attractive, healthy girl of 16 years, possessing a good sense of humor, and independent and self-directing to an unusual degree. She enjoys her school work, has fairly normal social activities, appears to be well adjusted. So far as it has been observed, the presence of this handicapped girl in the home would seem to have created no problem with the other children.

Anna May J.

We might turn to the picture of another child with an equally serious pathological condition.

Anna May J., a small, frail, colored girl of 14 years, was referred to the Eye Clinic four years ago by the school clinic which had made a diagnosis of progressive myopia. On examination, it was found that she also had cataract in the left eye, vision there being limited to hand motion. Extraction was advised, the uncertain prognosis being explained to the parents. The cataract was removed with little resulting visual

improvement. Some time later Anna May suddenly became blind in the right eye, due to detachment of the retina. An operation was performed for reattachment, with good results. For the past three years, vision of 20/100 in the right eye, and hand motion in the left eye, has been retained. The prognosis is definitely bad. In regard to her general physical condition, a month's stay at a convalescent home each summer for the past three years has been helpful.

Anna May is timid and sensitive, appears almost sullen, but is immediately responsive to any attention. The second youngest of six children, she is the father's favorite and is very close to her mother. Much real affection seems to exist between the parents; at the same time, there is often serious friction in the home, chiefly in relation to Mrs. J.'s two oldest children, who were born out of wedlock before her present marriage. Mr. J. has never been able to accept these children, is very critical of their behavior, in contrast to his easy handling of his own children. Because Mrs. J. has much conflict and guilt in the situation, she is less able to handle the family problems.

Anna May was early referred to a sight-saving class, where she has made a fairly good adjustment. She has always had some difficulty in keeping up with her grade; her return to school last winter, after being out one term on account of the retinal detachment, was marked by discouragement. This past summer she was given an opportunity for work in a small summer school group where much individual attention was possible. A later report stated that she had "blossomed like a flower," was gay and spontaneous, showed initiative and leadership. An interesting feature of the report was the child's responses to a questionnaire. She said she enjoyed most of all taking care of pets, working in a garden, helping her mother cook. Actually, she has none of these interests. She expressed strong interest in fairy tales, and a desire to learn to skate, swim, and dance. All this seemed to point to an active fantasy life, a certain lack of satisfaction in reality. Her recreation, which has been necessarily restricted because of her diagnosis, has centered in the neighborhood church clubs, her special interest being handwork.

When school reopened in September, Anna May again became fearful. The mother felt the child's vision was worse and brought her to the clinic, where the doctor found the vision was rather better than usual. It was felt there was a definite relation between the emotional upset and possible suppression of vision.

Whatever adjustment Anna May may have achieved has been at great cost, and would appear very tenuous. We see a child who is the object of much affection in the home, but who is probably rendered insecure and bewildered to some degree by the friction that exists among others in the family group. Because of her personality make-up, she is less able to meet frustrations. The mother is largely preoccupied with her own problems, which she is definitely attempting to solve, but meanwhile is less available for help to her child. Anna May's fantasies might indicate considerable conflict and feeling of deprivation regarding her reality situation. It would seem a better school adjustment could be achieved. In addition to continued contact with the mother and the school, closer work with the child is indicated, on the part of the social worker, to gain a clearer understanding of her feelings and help her work through some of her conflicts.

John C.

The worker's awareness of the psychological implications of a situation will make her ready to offer help in cases that otherwise might indicate routine handling.

> John C., a 16-year-old boy, was referred to the Social Service Department by the family physician for arrangements for hospitalization. In the clinic, a diagnosis of phthisis bulbi was made, the condition presumably having been present from birth. Admission for enucleation was recommended. John, the only child of middle-aged Italian parents, is tall, awkward-looking and self-conscious, with nervous mannerisms. He appears immature emotionally, is probably of average intelligence, is in his second year in high school. Both John and his mother were apprehensive, though eager for the operation. The father returned with them for a second interview, in which they seemed quite reassured. Both parents asked if John might remain in the hospital following the operation until he had been fitted with an artificial eye. The usual length of stay, the wearing of a dressing or patch on discharge was talked over and all seemed to accept it. The father, an intelligent, skilled workman, unemployed, appeared quite stable, while the mother seemed dependent and emotional.
>
> John was nervous on admission, but controlled himself quite well. Following the operation, he was apprehensive as to his

eye, complained of exaggerated pain and discomfort, and requested much attention from the nurses. After a few days he became more poised, and began making friends with the others in the ward. He was able to talk a little with the worker as to his feelings regarding his eye, the shame and embarrassment he had always felt in meeting new people. Apart from his own immediate family, his girl friend was the only one who knew of his coming to the hospital. Worker talked with him with a view to preparing him for discharge and he no longer seemed so upset. In a conference with the doctor, referral to the psychiatric clinic later was considered, because of the rather severe trauma the boy seemed to have suffered. The mother came in, in response to the notice regarding discharge. She became extremely upset, saying she could not possibly dress John's eye; she knew she would faint if she saw it. She begged to have him remain in the hospital. John himself became upset at this point, and with a rush of feeling told the worker how he had been happier in the hospital than ever before, and how he dreaded returning home and meeting friends. John was given an opportunity to talk out his feelings a little and seemed to gain some release. It was recognized that the whole experience had been traumatic for the mother as well as the boy, and that the mother would probably have a very destructive influence on him at this point. Accordingly, with the doctor's approval, transfer to the Convalescent Hospital was arranged. John was elated and the mother wept with joy.

Worker discussed the situation fully in advance with the superintendent of the Convalescent Hospital and kept in close touch later. John wrote occasionally, apparently very happy. Reports came back that he was gradually adjusting very well, was dropping some of his childish behavior. An old mannerism of dropping his head to one side, as though to hide the unsightly eye, was less evident. After a month or so his general physical condition has improved and he seems less nervous. He is happy there, only mildly interested in returning home. On a recent visit the mother, who almost fainted, apparently from excitement, on her first visit at the Convalescent Hospital, requested that he be kept there three months longer. Since he is now ready to be fitted with an artificial eye, it is being arranged that he return for a few days, to permit of a clinic visit and the necessary fitting. Because of the emotional factors involved, and the question of the ease of adjustment on his return home, it is being explained carefully to him and his parents that he is to come down for the clinic visit, and to return to the Convalescent Hospital a few days later if he wishes. This will

probably be necessary in helping him adjust to the artificial eye. Referral to the Psychiatric Clinic is also being made in order that John may have the much-needed help with his problems.

We have here a boy with poor physical and emotional equipment, apparently closely tied to over-solicitous parents. It would seem he had reacted very strongly to the handicap of the unsightly eye, and definite damage to his personality seems to have resulted. The removal of the eye was evidently a real trauma to the boy and incidentally to the mother. Hospital discharge would doubtless have been too abrupt a transition from the protection of the hospital to the outside world which he had always found difficult. Fortunately, the facilities of the Convalescent Hospital were available for this transition period. His return home will present definite problems in which both psychiatric and case work service may be indicated until he is able to work out a more satisfactory adjustment. Work with the mother would seem to be part of the plan.

Defective Vision as it Affects Personality

May we touch on the problems in relation to squint cases? Invariably, the child is very sensitive about his appearance, quite out of proportion to the existing condition. In the milder cases, one wonders how much of the child's feelings may be due to the attitude of parents or others.

This leads in to the problem of wearing of glasses. Many children adjust well to glasses from the beginning. We note this in regard to the myope and hyperope, to whom the world before was misty and vague. With others, a matter-of-fact or encouraging attitude on the part of the parents will often help the child to accept glasses readily. Muscle cases are probably the most difficult, especially when the child's good eye is occluded. It is found the mother may need frequent reinterpretation as to the purpose of the glasses, and encouragement in helping the child to wear them steadily. And how familiar we all are with the mother who at the child's first examination asks anxiously in his presence, "Will he *always* have to wear glasses?"

School plays a relatively large part in the child's life and is bound

to present many situations which may or may not rate as problems to the child or his parents. May we think at present in terms of the child for whom a sight-saving class is recommended? If the child is just entering school, this may involve practical adjustments, such as arranging for transportation to a fairly distant school, or the transfer of an older child in the family to accompany the six-year-old. Unless the parent is convinced of the value of such placement for the child, there may be much hesitation, perhaps a desire to try him out first in a regular class in the nearest school. Do we always stop to consider, too, that a child's referral to a sight-saving class may be a threat to parents, in the implication that the child is handicapped in competing with his fellows? This is especially true of the ambitious parent who has a need to live out his own life in his child. While the parent is working through these practical or emotional problems relating to the special class placement, the child may take on the parent's anxiety.

In our attempts to help the parent, do we sometimes fail to prepare the child for the transfer to the special class? Frequently this may be a child who, because of his visual handicap, has been doing badly in the regular class, has been under tension and unhappy. The actual change brings great relief, as a rule. To a number, however, it may mean an uprooting from one's friends and being projected into a strange situation, sometimes with the stigma of being handicapped. The worker can help the mother minimize the frustration in this experience, and emphasize the advantages.

Occasionally we find in the sight-saving class the older boy who becomes restless, or shows beginning behavior problems. These symptoms undoubtedly have a special significance in each case, and are worth taking into account. Is it a part of the adolescent's striving for independence, or, more specifically, resistance to the more sheltered situation of the special class, or a dislike of being marked out from his fellows? It may tie up with other conflicts—in any event, if a case work relationship can be established with the boy, an opportunity can be given him to talk out his feelings and together an attempt can be made to effect some adjustment.

The child whose vision has improved to the point that a transfer from the sight-saving class to the regular class is recommended is occasionally in need of help in effecting this adjustment. The

regular class naturally is a less sheltered situation and may give rise to problems in the individual child before he fits in to the new group.

Robert B.

Robert B. left the sight-saving class after a three years' attendance. He is a thoughtful, rather withdrawn boy of 13 years, who had responded well to the special class situation. The oldest of five children, in a home from which the father had deserted, he had been given considerable responsibility by the mother, who had a need to share her anxieties with him. Soon after the transfer to regular class, Robert came to the eye clinic complaining of poor vision. It was found there was no change. Because of a fairly close contact with the boy, the worker was able to suggest directly to him that perhaps he did not yet like the new class very well. Robert, who is very honest with himself, admitted this and saw the relation to his complaint. He was pleased with the worker's suggestion that she get in touch with his new teacher, since we knew the boy so well. At the school, some understanding was given of Robert's need for special help at this time. The boy came in at intervals to see the worker and things progressed smoothly until September, when he again came in with complaints of poor vision. The old situation had been recreated when the family had moved to a new school district. In the pressure of work, the worker had overlooked this possibility, and apparently Robert was not yet able to meet the new situation himself.

Summary and Conclusions

We have been considering some of the factors that would seem to relate to the emotional adjustment of children with visual handicaps. We have attempted to explore several cases, keeping in mind the implications of the particular eye difficulty involved in each, and trying to form some evaluation of the child's own feelings in relation to the handicap, as well as the attitudes of others which might seem to have affected the child in his adjustment. It would seem significant that the better adjustment was being made by the child whose parents were emotionally mature and whose home was comparatively free from friction and emotional strains. This, too, was evidently a child with a better personality equipment, a greater

capacity within herself to handle her problems. It would seem indicated from our discussion that the handicapped child has the problems of adjusting to his handicaps and also of dealing with the attitudes of others. In cases where lack of understanding or emotional blocking exists in the parents or those closely concerned with the child, we have found that these factors definitely tend to increase the child's problems. The function of the social worker would seem to be to evaluate each child's problems, to secure a picture of the child in relation to his whole situation, to determine whether or not help is needed in making a more satisfactory adjustment and then to make such service available to the child or the parents. There might be need only for a careful interpretation to the parent of the doctor's recommendations, or the problems presented might indicate a long, intensive contact on the part of the worker. This might include individual work with the child on his emotional problems, or work with the parents in the hope that certain destructive attitudes toward the child could be changed. It could also include, as we have seen, close contacts with the school if the child has difficulty in that area. Working out recreation opportunities that will be within the child's limitations and acceptable to the child, is a frequent challenge to the worker. In brief, our aim is to help the child overcome as much as possible whatever personality damage has already resulted from his handicap and to work through to a healthy adjustment. Our study would seem to point to the value of as normal a way of life as possible for the child, offering adequate protection, but avoiding over-protection in order that the child may achieve a healthy independence and work toward a mature emotional adjustment.

Children with Temporary Eye Difficulties

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IN THIS paper have been considered children with eye difficulties which, though not in themselves temporary, have produced definite or marked handicaps for a temporary period. No special study has been undertaken to discover the extent or nature of emotional factors seeming to play some part in the care of children with eye difficulties, but rather an inquiry was made of one medical social worker in an eye clinic and two case workers in a private family agency for examples of the presence of such factors in their recent case loads. Out of this group thus obtained certain cases have been selected to illustrate the various ways in which emotional factors appear to influence the medical situation or the child's adjustment to it.

Perhaps the most common illustration of the interrelationship of the patient's physical condition and his behavior is the case in which the child is thought by other children to be different. It is not necessarily only the serious eye condition which has such meaning for the child. Children who have a good prognosis as far as physical handicap is concerned may nevertheless be disturbed by being disfigured for a temporary period or by being the object of curiosity or anxiety as a result of treatment which marks them as being unlike the rest of the group. Although one child may not like to wear glasses because she is teased by being called "four eyes" or other more derogatory names, another child liking her glasses may pretend to read like a "grown-up," while she takes her glasses on and off with a good deal of affectation.

Another reaction which bears no relationship to the child's diagnosis is the fear of doctors and of their treatment. This fear is usually built up as a result of earlier experiences with doctors and hospitals, into which the child was forced without having any preparation, or ones in which he had been accorded less understand-

ing attention than might have been arranged. Although much medical care has been achieved through parents' use of their authority over their child without consideration of the child's thoughts and feelings, much damage has thereby been done to his feelings, which in turn conditions his subsequent response to later medical treatment. When the child grows to the age at which he may make his own decisions, he often avoids these experiences which are so full of painful recollections for him.

In doing refractions, as well as surgery, it is important to remember that it is the patient and not his eyes alone which have been brought for treatment and that all factors which may affect his outlook on life should be taken into consideration.

Helen, a 6-year-old child with congenital glaucoma, entered the hospital for an operation. Hot, flushed, and crying hard, she resisted the examination until a rise in temperature led to the postponement of the operation.

Another child with high myopia was near tears when she was admitted and was so upset during the examination that the medical student could not ascertain her vision accurately. When the social worker noticed that her mother wore very thick lenses she asked her if she were worried about having to wear glasses. She nodded and said she was afraid she couldn't play ball. Later, when the school notified her that her glasses were ready, she cried and begged for permission to postpone going to the clinic for them. Her surprise and relief were so great when she saw her quite ordinary glasses in a mirror that they confirmed the worker's impression of her earlier fear that they would be "real thick." This fear she was able to express only when there was no longer the uncertainty. She broke her glasses once and bent them several times which might indicate that she still was not pleased at the idea of wearing them.

John, a 13-year-old boy, withdrawn and shy, and not doing well in school, came to a private family agency because of his behavior toward his sister, one year younger, who was doing much better work than he. For years he had shown considerable jealousy toward his sister whom he felt had received much more approval than had he. In a search for understanding of his poor school performance and his inability to enter spontaneously into group activities, the agency arranged an eye examination. When he secured glasses which were recommended because of myopia, he expressed great relief about no longer having to sit next to his sister in class in order that she

could read for him whatever was written on the blackboard. Therefore, not needing to depend upon his sister, he entered much more freely into activities, both inside and outside the schoolroom and showed a rather sudden spurt in his school achievement. Though long recognized as a behavior problem, his relationship with his sister and other children had not been discovered to be fostered by impaired vision. When the latter was corrected, however, he found within himself an unsuspected force for dealing with those relationships. Freed in part at least by vision improved through its correction, he likewise found a motive for continued attention to care of the eyes.

Several children with interstitial keratitis which had developed to the point where they could see only hand motion during the early treatment period, even though the prognosis for useful vision was good, have been observed to have some of the same behavior characteristics as children who have been blind for a much longer time.

William was withdrawn, lacking in confidence to move about, and his masturbation, which had been observed before, became more marked as he was thrown more and more upon his own resources without opportunity for receiving many external stimuli to pleasure and love or constructive physical activity.

Alice, 11 years of age, was unresponsive and restless and clung to her mother as she was led about the clinic, partly because of her inability to see, but also as a means perhaps of getting the additional reassurance and love which she needed when her other sources of security were threatened. As her vision improved she gained in weight, ate better, became more relaxed and interested in things going on about her, as well as more independent. Such regressive behavior is often disturbing to the parent and may easily be mistaken during its course for lack of emotional development.

The extent to which an emotional disturbance can produce physical symptoms similar to those which have an organic basis is illustrated by the following two cases:

Jane had been sent home from school because she did not see well. Prodding during her eye examination in a clinic raised the report of her visual acuity from 20/30 right and 20/100 left to 20/20 in both eyes. The examination did not

reveal the need of glasses and the ophthalmologist sent her back to school with the report that she was a "malingerer." Although this "treatment" answered the question of the extent of organic damage to the eye, it did not help the child to use her eyes more effectively.

In this instance the medical social worker in the eye clinic did not go further, thereby losing an opportunity to participate in treatment of the child's eye difficulties. From another agency it was learned that the child's father drank to excess and that other family difficulties had been a source of worry to the mother, who wished to conceal them.

Contrast the treatment of this child with another 10-year-old:

Paul was sent home from school because he couldn't see the blackboard or fine print and complained that his eyes hurt him. To the teacher he was quite annoying because his attention wandered and it took him much longer than other children to do his written work. The ophthalmologist in this case recognized the possibility of emotional involvement when no eye pathology was discovered to account for his low vision, and referred him to the social worker for study. Although it was difficult to learn anything of the child's situation, since his mother was suspicious of any discussion of her relationship to the boy or the kind of home she was able to make for him since she worked all day, it was learned, after she felt more confidence in the social worker, that she was divorced, and that it was disturbing to her that her child very much resembled his father. Although the child idolized his mother and repeatedly sought evidences of her love for him, the mother whipped him for minor misbehavior and implied that he left his poor grades at school when he brought home good ones and in general gave him no approval for work well done. With protestations that he could not read, he begged his mother to read to him in the evenings. However, such a request was not usually met as she and a friend, who shared one room with her and the boy, often entertained men in their room "at all hours of the night" while the child was shut up in the bathroom by himself. When he was later placed in a foster home, where his need for love and attention was filled and constructive relationships were established which helped him to attach less importance to the sordid experiences in his own home, he no longer complained that he could not see the blackboard and the school forgot that he had had difficulty with his vision.

These two cases are interesting against a background of theories which have been expressed in the field of psychoanalysis. In the material which is produced by patients undergoing analysis, the eye is often identified very closely with the sexual life; and thoughts, feelings, and experiences of the latter are often displaced upon the former. To look at something forbidden in early childhood is almost as serious in the mind of the child as actually doing something forbidden, and the eye is often utilized subconsciously as a means of punishment. In adults, likewise, this organ may be selected for punishment for sexual experience or feelings associated with sex. Whether the latter child actually witnessed episodes which were disturbing to him or whether he fantasied about what transpired behind the locked doors, is not known, but there is sufficient basis for believing he was considerably disturbed about this situation centering around his mother. In relation to this, the old Greek myth of Oedipus, and of how he put out his eyes when he realized the significance of his close relationship to his mother, comes to mind.

Organic eye difficulties may serve to meet the individual's emotional needs in such a way that the person may exaggerate their importance and hate to relinquish them until the needs are filled by other means.

> Marvin, age 13, came to the family agency at the suggestion of the school principal because he was failing in school in spite of earlier satisfactory performance. In discussing school he said the school nurse had told him he would become blind in three years unless he secured glasses. Such an outcome did not seem undesirable to him as "people do lots of nice things for the blind" and "the blind can make money without having to be too smart." Thus blindness seemed to him a means of escape from his inadequacy and feeling of not being loved. The nurse, since she thought he should have glasses, had emphasized the need of an eye examination, but had not thought or said that blindness was a probability. Rather, the boy had dramatized his eye difficulty as a basis upon which he might win attention and understanding. After he had come to feel warmth in his relationship with the social worker, he was willing to go to the eye clinic for an examination. Glasses were recommended for a refractive error which held no threat of blindness. When the case worker provided the glasses which

represented his concern for him, Marvin found it possible to give up his fantasy of becoming blind and seemed to be glad that at last he had secured correction of his eye defect.

The feelings of the family as well as those of the patient are often determining factors in the working out of plans for medical care.

Mary, a 4-year-old child with congenital cataracts, was quite conspicuous in the family group because of the constant turning of her head to one side as she peered at everything very closely. When the social worker visited in the home, Mary touched her dress and put her face in her lap in an attempt to see the pattern of it and what she held in her hand. No attempt had been made to secure medical treatment for Mary, because her mother, who was also blind, had thought that she would wait until Mary had entered the school for the blind, which she felt sure would attempt to arrange medical care for her. This had been the channel through which she, herself, had received medical care, although in her case it had been of no avail because of the years which had passed before she was admitted to the school. She had married Mary's father after his nose had been bitten by a horse, leaving him rather repulsive in appearance. His hesitation about accepting the suggestions regarding possible medical care for Mary in a clinic indicated his fear of what Mary's attitude toward him might be if she were able to see him plainly. (So often resistance to a medical plan means that for some reason the difficulty is serving an emotional need which the individual sees no other way of meeting.) After arrangements were made for him to have plastic surgery done on his nose, he became more interested in carrying through the suggestions for Mary with the result that she did have needling and glasses. This treatment made it unnecessary for her to have special schooling, to say nothing of not needing to be admitted to a school for the blind.

Thus we see some of the feelings of parents entering into the whole situation and influencing in a surprising degree the extent to which medical treatment is completed.

Another illustration of the way in which not only the child's own feeling but emotional factors within the family situation affected the carrying through of established medical plans is presented:

Eleven-year-old Robert had esotropia in the right eye. Occlusion of his good eye had been prescribed and the recommendation had been carefully followed in school, where he sub-

sequently became a constant problem, while at home the family took little care in encouraging him to use the occluder. Robert was doing little school work and the principal thought that he was using the occlusion as a means of escape from such tasks as were assigned. When his behavior became more difficult for the school to work with in the classroom, the school nurse came to the clinic to raise a question of the value and importance of continuing the medical treatment which seemed to be so intensely upsetting to Robert that he found it necessary to protest vigorously against it. His protest manifested itself in expressions of arrogance and hostile aggressiveness which seemed his only way of hiding his fear that he was no longer a real boy. In other words, his loss of vision was a symbol to him of his loss of some of his manly qualities which at 11 years were particularly important for him to feel he possessed. The school suggested his transfer to a sight conservation class, where he could be given more individualized attention. There he created few difficulties. In spite of the fact that Robert might have felt even less adequate there with other handicapped children, he was able to continue using the occluder without the same expression of resistance to it. This may have been due to his being given recognition as an individual and being given a chance to make simple decisions for himself.

When occlusion was no longer advised, as surgery was being considered, the doctor recommended that the child be returned to his regular school. Although the child himself seemed to be quite eager to return to his own neighborhood school since he would be with all his friends, his father became quite irate and could not understand why the doctor should discontinue a form of treatment which he said had done more good for Robert than anything else that had been tried. He was vehement in stating that he intended to continue the procedure at home even though Robert was not made to do it at school. His father, an extremely egocentric person, had had many difficulties with the school in relation to all his children and they in turn had found it impossible to talk with him. It finally became evident that the father's real desire was for Robert to remain in the sight conservation class, as he was convinced that he would not get along well in his old school since he and the principal had never agreed on what was good and necessary for his son. On several occasions he had attempted, he said, to talk with the principal but the latter had not seemed to understand his point of view. In an earlier experience with the school when Robert had a fractured arm, he had insisted that he be put back a grade or placed in the opportunity room,

without consideration of what this would mean to Robert, whereas the principal saw no reason for any such adjustment. In talking with the school he seemed to be extremely overprotective of Robert, yet his failure to consider Robert's own feelings gave his concern a punitive quality. He insisted that he would not send the child back for further medical care, since the doctor had so "inconsiderately and unwisely" stopped the only treatment which he, the child's father, felt would be effective. When it was suggested that he come in and talk with the doctor, he frankly said that unless he could convince the doctor that the child should remain in the sight conservation class, there was no point in his coming in to see him. He finally agreed to come, but did not do so and the child's treatment was terminated at that point.

In such a situation as this, more than routine follow-up procedures of any sort are necessary and further instruction of the father would likewise be of no avail. Only efforts which would make the father feel that he was controlling the situation, and was really more adequate than he believed himself to be, would be of any help in assuring the child's getting adequate medical care. Thus case work service is a necessary part of any program for the conservation of vision.

Eye difficulties are not something apart from the rest of the child's life, but are an aspect of a more general problem. The setting in which they arise is always important. The whole situation affects the child and the roots of the emotional factors lie within the family itself. There is the need, then, not only of discovering the meaning to the child of the eye defect and its treatment but also of understanding his social and emotional life as a whole. Increasing knowledge of people indicates that behavior is only a symptomatic response to the needs and strivings developed in the person by his life experiences and that the individual's basic needs must be understood before a direct attack on such a problem as resistance to medical care for a defective eye will meet anything but failure.

Are we going to treat Marys and Bobs and Joes in our clinic or only cataracts, myopias, and glaucomas?